FILED JAN 23 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44075

Registration District No. 836   Primary Registration District No. 8366/00   Registrar's No. 63

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Parma "Rural" (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community about 10 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stoddard
(c) City or town Near Parma "Rural" (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ______ years.

3. (a) PRINT FULL NAME Robert Starns
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bertha Starns
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased June - 23 - 1872 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
68	5		___ hr. ___ min.

9. Birthplace Alb. (City, town, or county) (State or foreign country)
10. Usual occupation Farming
11. Industry or business
FATHER 12. Name John Starns
13. Birthplace S.C. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Uk.
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Mr. Ola Davenport
(b) Address Gideon Mo. 11-24-40
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Malden (Month) (Day) (Year)
(c) Place: burial or cremation Malden
18. (a) Signature of funeral director Landess Funeral Home
(b) Address Campbell Mo.
19. (a) 12-12-40 (Date received local registrar) (b) Laura Hopkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 23 year 1940 hour 11 minute 15 a M.
21. I hereby certify that I attended the deceased from 11-22-40, 19__, to 11-23-40, 19__;
that I last saw him alive on 11-23-40, 19__,
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fracture Cervical Vertebra	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 11-22-40
(c) Where did injury occur? No 2 Hiway New Madrid Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? On Highway (Specify type of place)
While at work? No (e) Means of injury Auto Wreck
23. Signature W. T. Gilbert (M. D. or other) M.D.
Address Parma - Mo   Date signed 11-22-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer
District File Number 141
Date Filed 11/9/43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

o. 2B
-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44075

Registration District No. 836 Primary Registration District No. 6102 Registrar's No.

1. PLACE OF DEATH.
(a) County Stoddard
(b) City or town Elk T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Robert Starns
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 68 | Months 5 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 23
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tract. Cervical Vertebra	
Due to No Collision + Concussion of Brain	
Due to Bridge + Embankment + The highway not straight	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 21 M
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) acc
(b) Date of occurrence 11-22-1940
(c) Where did injury occur? New Madrid (City or town) Mo (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? On Highway (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) MD
Address Gideon - Mo - Date signed 2-20-41